Missouri Department of Mental Health
Division of Mental Retardation and Developmental Disabilities
Habilitation Center Five Year Plan
March 10, 2004
Approved by Mental Health Commission March 11, 2004

Remarks From The Division Director

I am very pleased to present this Habilitation Center Five Year Plan proposal to the Director of the Department of Mental Health and the Mental Health Commission. It is a plan to strengthen Missouri's full continuum of supports for persons with developmental disabilities and their parents and guardians. It is a plan that integrates and coordinates the efforts of habilitation center staff with those of regional center staff in concert with parents/guardians and community providers ---- efforts to ensure informed choice, community integrated living environments, and improved living arrangements for persons currently residing in Missouri's habilitation centers. It is a plan characterized by flexibility and focused on meeting each person's needs, one case at a time. It is a plan that is responsive to the U.S. Supreme Court's Olmstead Decision of 1999, as much as it is a plan to ensure Missouri's habilitation centers function in the future as the ultimate public safety net focusing care only on the state's most vulnerable citizens for whom there is no better option to meet their needs.

At times, discussions about the long term care needs of persons with developmental disabilities in Missouri can become polarized between habilitation centers and community living options. Proponents of one living arrangement might decry what they perceive to be the shortcomings of the other and contest resource allocations to one or the other. With this Habilitation Center Five Year Plan, it is my sincere hope and intention that the public in general, but most importantly, our consumers and all who support them, will understand that both options are vital to the continuum of supports needed by a diverse population of persons with disabilities.

State-operated long-term care facilities that offer structured, twenty-four hour oversight and support are currently needed to fill the existing gap in support services available from private sector providers for many persons who are high risk or medically fragile. Moreover, it may always be that for certain MRDD high need groups, "state-operated" residential programs will be needed to provide the ultimate safety net for those whom the private sector cannot or does not choose to support.

While habilitation centers are meeting a critical need for the majority of residents, there are better alternatives for a substantial number of other persons who currently reside there. Habilitation center residents and their parents/guardians should know what alternative community living options exist for them and should be assisted in exploring these options that are increasing every day. Many persons who have lived in habilitation centers for a number of years can also choose and expect to be successfully accommodated in the community.

It is fortunate that funding for an individual's support plan can follow from the habilitation center to the community. This funding will ensure that all the services needed to make the transition to the community a sustained success are, in fact, available. We will also

ensure sufficient funding will continue to be available so that the habilitation centers are in good repair, well staffed, and fully equipped programmatically to support persons for whom that is the best care option.

Today's expanding community based living infrastructure is growing in its capacity to meet the diverse needs and community option demands of the MRDD population. Up-coming generations of children with developmental disabilities, who are being raised in the community, are looking to this infrastructure to enable them to remain integrated into community life once they reach adulthood. Others who will be seeking this option include hundreds of adults who have been cared for by their parents in the community. Parents of these adult children are now facing advanced age and, in increasing numbers, they are likely to be relying on the state to provide long-term support to their sons and daughters. They want their adult children to continue to live in the community.

These demographic changes and the growth of community provider capacity are occurring at the same time as Missouri must anticipate how best to address aging buildings on its habilitation center campuses. The confluence of these factors necessarily influence plans for habilitation centers and how we can best utilize them for special need groups within the MRDD population.

The following plan is designed to inform habilitation center residents, as appropriate, of community options which might be available to them; to work closely with parents and guardians to assist exploring community options; to move residents from residential homes at three habilitation center campuses that will soon require substantial capital improvements; and to continue to build a strong service continuum that ensures quality support in the habilitation center and quality support in the community.

Throughout the implementation of this plan, feedback from consumers, parents/guardians, legislators, service providers, SB40 Boards, and all those who work on behalf of persons with disability will be vitally important to us. Advisory groups to obtain feedback will be established at three habilitation centers where we anticipate vacating certain residences over the next two and one-half years. Additionally, meetings will be held at convenient times and locations with parents/guardians and the public to keep these crucial advocates informed and to respond to their issues and concerns.

The Division encourages personal contact at any time. Individuals may contact administrators at the habilitation centers, regional centers, or feel free to contact the Division's Central Office in Jefferson City by calling 573-751-8676. For this plan to succeed, goodwill, cooperation, and feedback is needed from all of us who work to ensure safety and quality of life for persons with developmental disabilities. Thank you for all you do on their behalf.

Anne Deaton, Ed.D., Division Director

I. Introduction

This Five Year Plan is divided into two parts—short range objectives and long range objectives.

The short range objectives have a time frame of two and a half years (July, 2006). The short term plan focuses on the action steps necessary to transition approximately two hundred and twenty-five (225) persons to community residential placement.

The long range objectives encompass efforts that begin in the first year of the short term plan (2004), and continue over the five years to ensure the following outcomes by July, 2009:

1. Continuum of care options are available for persons with mental retardation and developmental disabilities who cannot be supported in the community. This includes a strong public safety net for persons who have high risk medical and behavioral needs and those requiring emergency and temporary support.
2. All persons who currently reside in a habilitation center, but who can be supported in a less restrictive environment, have the choice and opportunity to reside in the community, supported by a person centered plan that meets their needs.
3. The number of habilitation centers that comprise Missouri's public safety net matches current and projected consumer need for the most structured, restricted residential setting;
4. Residences at habilitation centers are in good repair, attractive, homelike and provide for privacy;
5. Facility staff participate in a very strong orientation and on-going training program to equip them to use "best practices" in all aspects of supporting residents;
6. Quality assurance mechanisms work effectively to expose any weakness in habilitation centers or community provider service delivery, internal monitoring, policy, and staff training systems.

All aspects of this plan are grounded in the principles and values of the following documents (See Appendix A):

1. Department of Mental Health Vision and Values;
2. Missouri MRDD Quality Outcomes for People and Agencies:
3. "Let's Get Moving" Transition Manual;
4. Supreme Court Olmstead Decision Guidelines;
5. Division of MRDD Person Centered Planning Guidelines;
6. Informed Choice Standards;
7. HIPAA Confidentiality Assurances

Moreover, overall direction and implementation of the plan will be driven by the Division's beliefs in:

1. All persons are treated with respect and have every opportunity for informed consumer choice through the person-centered planning process;

2. Children belong in families and everything possible must be done to support the family unit;
3. All persons deserve to live in the most integrated, quality environment that will provide for their health, safety, personal development, and happiness;
4. Staff and family members who come in direct contact with people make the biggest difference in their well-being; the knowledge and experience of staff and family are critical resources for the improvement of service delivery.

Detailed plans beyond July, 2006 are dependent on important data and information that will be available from several critical sources, including:

1. The study of habilitation center buildings conducted by the Office of Administration, Division of Design and Construction (due Fall, 2004);
2. Progress toward short term objectives;
3. Feedback from consumers, parents/guardians, advisory groups and other key stakeholders; and
4. Statutory and/or fiscal factors currently unknown to the Division.

II. WHAT THE CHANGED SYSTEM WILL MEAN

1. Short Range Objectives:

   a. Two hundred and twenty-five (225) persons who currently reside in buildings which have been identified as outdated for residential use will be transitioned to more appropriate living environments. Some of these individuals will relocate to other residential buildings at the habilitation center. A total of 225 persons currently living at habilitation centers will be transitioned to community living arrangements. However, these persons are not necessarily the same persons who presently reside in the out-dated residences targeted for closure (see Appendix B).

      These moves will result in a change in total capacity.

   b. Based on the results of a study to be conducted by the Office of Administration - Division of Design and Construction, and completed by the Fall of 2004, the Division of MRDD will evaluate the “goodness” of all buildings on its campuses (Nevada, Marshall, Bellefontaine, DDTC and Higginsville) with regard to their capacity to meet the functional and programmatic needs of residents on each campus.

   c. Multiple opportunities will exist for consumers and parents/guardians to know about community residential options and to receive assistance in exploring these options (e.g., Provider Fairs, Provider Tours, Informed Choice sessions on campus);

   d. The Division’s new policy on admissions to habilitation centers (see Appendix D) will be evaluated on a bi-annual basis to determine if revisions are needed to assure that the policy is successful in carefully screening admissions to habilitation centers and assisting consumers, families and guardians to live in the least restrictive environment;

e. The Division will provide intensive monitoring for residents transitioned to community living arrangements to ensure safety and to ensure support plans are successfully implemented.

f. The Division's plan for management consolidation at Bellefontaine and DDTC will take effect by July 1, 2004. We will also consolidate some administrative functions at Higginsville and Marshall Habilitation Centers no later than July 1, 2004.

2. Long Range Objectives:

a. Missouri will have the number of habilitation centers necessary to provide a strong public safety net for current and future consumers who have needs evaluated as high risks, and those who need emergency/temporary care but cannot immediately be supported in the community;

b. Buildings on habilitation center campuses will be in good repair, modernized and well-equipped to meet the residential and programmatic needs of the residents. Maintenance budgets will be adequate to maintain buildings;

c. Future budgets will request funds to support a plan for removing buildings which are not cost-effective to renovate for existing or alternative uses;

d. Budget dollars will be available to meet building capacity needs on campus in accordance with cost benefit analysis;

e. The Division will be able to recruit and retain trained staff, including direct care, professional staff and case managers.

III. ACTIONS THAT WILL CHANGE THE SYSTEM

The Division has identified a number of activities that will assist consumers, parents/guardians and family members as transition activities are taking place. All of these processes will be continually reviewed, updated and reported upon in quarterly public meetings.

1. Short Term:

a. A Facility Advisory Group will be established at each habilitation center by March, 2004. The purpose of the advisory group will be to receive on-going information on transition planning, participate in setting guidelines for community supports, and looking at any workforce and community impact resulting from moving residents to the community.

Each advisory group will include consumers who can participate, family members of persons living at the habilitation center, representation from Parents' Association, employees of the habilitation center, the Superintendent of the facility, regional center staff, community providers, Regional Council members, representation from S.B. 40 Boards, and

community members (i.e., local Chamber of Commerce or Economic Development Director);

b. Ongoing Informed Choice training will continue at all habilitation centers to assure that all consumers and guardians/family members have access to complete, up to date information on choices for residence;

c. An informational web site will be set up and maintained;

d. The Division will continue the review and implementation of its Transition Policy (which includes guidelines on admissions to habilitation centers);

e. The Transition Manual will be utilized as the Division's guide to the processes of transition to the community;

f. Quality assurance measures to assess the effectiveness of the Division's efforts will be established;

g. The Division will study the habilitation center campus reviews which the Division of Design and Construction completes (Fall, 2004) and will develop a response by January, 2005;

h. The Division will continue partnerships with SB 40 County Boards and the provider community to increase community capacity.

2. Long Term:

a. Utilize information from the Division of Design and Construction, Advisory groups, other key stakeholders and the progress of short range objectives to develop detailed extensions of this plan;

b. Review and assist in maintenance of an informational web site regarding these initiatives;

c. On a quarterly basis, a report will be sent to the Director of the Department of Mental Health and the Mental Health Commission on the effectiveness of action steps designed to achieve desired outcomes for the short and long term plans. As necessary, the plan and action steps will be adjusted to ensure desired outcomes will occur;

d. Continued partnerships with SB 40 County Boards and provider community to increase community capacity.

IV. PROBLEMS/ISSUES TO CONSIDER IN SYSTEM CHANGE

Systems' change means systems' challenges. Problems/issues that must be addressed throughout the five (5) year plan include those outlined here:

1. Fiscal Concerns:
    a. Short Term:

1. Sufficient budget resources to support consumers in the community (e.g., case management, quality assurance);
2. Access to one-time funds for consumers moving to the community (e.g., for utility set-ups, household goods);
3. Local economic impact;
4. Analysis to maximize resources (i.e., buildings and land);
5. Flexibility of budget resources

b. Long Term:
1. Maintaining sufficient level of resources to provide or purchase ICF/MR services;
2. Additional community resources to serve aging MRDD population in the community

2. Community Contract Provider Capacity to Grow:
a. Short Term:
1. Inadequate DMH contract provider rates to support expansion of services;
2. Direct care staff recruitment and retention
3. Support existing provider base and develop new service providers.

b. Long Term:
1. Development of new community services to meet changing needs of consumers;
2. Develop career path for direct care support professionals

3. Proposed Legislation:
a. Proposed House Bill 1323 on downsizing or closing mental health facilities;
b. Senate Bill legislation to sell Midtown Habilitation Center property has been passed.

4. Other Issues:
a. Development of state-operated community settings, as necessary;
b. Maintaining safety net for individuals evaluated as having high medical or behavioral risks who cannot (either temporarily or long-term) be supported by community providers;
c. Collaboration with other stakeholders to integrate multiple systems for individuals with dual diagnoses;
d. Outreach—communication with families, consumers and other involved parties impacted by a developmental disability.

The Division will use various tools and mechanisms to address the issues stated above. In regard to the fiscal concerns, the Division is currently pursuing the use of a Management Advisory Team (MAT) which includes providers and Division staff. This MAT will learn by studying other states that have experience in these areas of start-up funding for providers, moving the money with the person, rate issues (both short term and long term), and flexibility of budget resources.

In addition, the Division is working with staff from the Office of Administration - Division of Budget and Planning to review and consider implementing strategies to maintain and

possibly increase the Division of MRDD's budget flexibility in order to allow dollars to follow a person from the habilitation center setting into the community.

On several fronts, the Division is also working with the provider community regarding direct care staff recruitment and retention issues and new development. The Division will also use local advisory groups in each of the affected areas of the state. The advisory groups will include local economic development experts, as well as consumers, family members, and providers. These local advisory groups will receive on-going information on transition planning, participate in setting guidelines for suitable community supports and work with local Chambers of Commerce and other groups to support these new developments.

Finally, the Division will continue its redesign around quality assurance systems in the community and in the habilitation centers. In addition to promoting the basic assurances of health, safety, and rights for the people we serve, our goals are to ensure consistency, efficiency, and accountability throughout our service delivery system. Initial steps have been taken to create a team from existing resources that will work closely with regional center and habilitation center's staff across the state. This team will monitor and provide guidance to the implementation of the Division's quality assurance policies and protocols which are designed to bridge existing gaps between the habilitation centers and the regional centers, particularly in activities relating to assurances outlined in the document, "Exploring Community Living As An Option" (Appendix C) for individuals who transition from habilitation centers into the community.

APPENDIX A

The Division used the following principles and values as groundwork for this plan:

1. Department of Mental Health Vision and Values:
    - **DMH Vision**: Missourians shall be free to live their lives and pursue their dreams beyond the limitations of mental illness, developmental disabilities, and alcohol and other drug abuse.
    - **DMH Values**: Full community membership, access, individualized services and supports, cultural diversity, dignity, self-worth and individual rights, prevention and early intervention, excellence, valued workers and competence.

2. Missouri MRDD Quality Outcomes for People and Agencies: The Division of MRDD uses the "Missouri Quality Outcomes" Discussion Guide. Those outcomes include:
    - **Quality Outcomes for People**:
      People belong to their community;
      People have a variety of personal relationships;
      People have valued roles in their family and in their community;
      People are connected with their past;
      People's communication is understood and receives a response;
      People are provided behavioral supports in positive ways;
      People are provided support in a manner that creates a positive image;
      People express their own personal identify;
      People have control of their daily lives;
      People have the opportunity to advocate for themselves, for others, and for causes they believe in;
      People's plans reflect how they want to live their lives, the supports they want, and how they want them provided;
      People live and die with dignity;
      People feel safe and experience emotional well being;
      People are supported to attain physical wellness;
      People are actively supported throughout the process of making major lifestyle changes;
      People are supported in managing their home.

- **Quality Outcomes for Agencies:**
      Action at all levels of the organization is consistent with a shared mission which is developed in response to the goals and aspirations of the people supported;
      The agency initiates and maintains positive working relationships with other organizations within and outside the service delivery system;
      The agency empowers staff to meet people's needs;
      The agency regularly evaluates its success in meeting people's needs.

3. "Let's Get Moving" Transition Manual: A manual created for use by the Transition Team at the St. Louis Regional Center and now being modeled statewide, to assist staff in supporting people as they move from habilitation centers to the

community. This manual is available through the Division of MRDD or can be accessed at the Department's web site at www.dmh.mo.gov

4. Supreme Court Olmstead Decision Guidelines: On June 22, 1999, the Supreme Court ruled that unjustified isolation of people with disabilities is discrimination and is prohibited under the Americans with Disabilities Act. Georgia had appealed the case to the Supreme Court, after the lower courts ruled in favor of two women with disabilities who sued the state under the "most integrated setting mandate" of the ADA. Title II of the ADA states that public services and programs must be provided in the most integrated setting appropriate. The Justices ruled that states must provide community options if three conditions are met:
    a. home and community-based services are appropriate;
    b. the placement is not opposed by the individual;
    c. the community placement can be reasonably accommodated, taking into account the needs of ALL people with disabilities served by the state.

5. Individualized Person Centered Planning Principles: Available from the Division of MRDD—similar to the Quality Outcomes.

6. Informed Choice Standards: The Division of MRDD is participating in trainings and other information dissemination to ensure that all consumers, parents/guardians and other interested persons receive information about their choices they have in how they receive long term care services. If interested, the Division staff will be actively assisting them to explore all options.

7. HIPAA Confidentiality Assurances: Federal guidelines requiring confidentiality of client records without a release from the person or their guardian.

APPENDIX B

The attached document is a spreadsheet which shows, by habilitation center the steps necessary to take to transition persons from the habilitation centers into the community.

APPENDIX C

Exploring Community Living As An Option
Division of Mental Retardation and Developmental Disabilities
March, 2004

This document is for consumers, parents/guardians and anyone wanting to understand the process involved in considering a community residential placement for a person who currently resides in a habilitation center.

The process described is not new, but it has been strengthened in several ways, including the requirement of a six month intense follow-up with a person who transitions to the community. This process has proven successful in providing for good transitions to the community. Still, we recognize there is always room for improvement, so the Division welcomes input from consumers, parents/guardians and providers about any aspect of this process.

This document begins with an introduction and overview of the steps followed in the transition process. It concludes with steps followed in a flow chart (see attached flow chart to hard copies—those by e-mail will not include the flow chart) to make it easy to follow the sequence of decisions and actions and the full involvement of residents, parents and guardians.

INTRODUCTION AND OVERVIEW OF PROCESS

First, it is important to know that residents at habilitation centers receive quarterly and annual assessments conducted by an interdisciplinary team. The purpose of the annual assessment is to identify support needs the person has in order to live as independently as possible in the least restrictive environment.

At the quarterly assessment, the team ensures that goals and objectives identified in the person's individual plan are still appropriate for that person. Based on the interdisciplinary team assessment and input from the person and parent/guardian, the plan and the identified support services may be modified.

The quarterly assessment is also a very appropriate time for the person's team to consider the option of community placement. If the person and parent/guardian choose to explore community residential placement, the following steps will be taken. In implementing these steps, there is close and thoughtful collaboration among consumers and parents/guardians, habilitation centers, regional centers, and providers of community residential placement and support services. More detail about each of these steps follows this listing of them.

When the consumer and parent/guardian choose to explore community living, the following steps will be taken:

1. Staff from both the habilitation center and the regional center will ensure a comprehensive support transition plan is developed for the person. The plan will include an assessment of possible transfer trauma for psychological/emotional and behavioral issues, and a plan to monitor and treat any manifestations. A Habilitation Center medical staff will identify any medical concerns that must be

monitored, as well as the frequency of future follow up activities, and will work with the Regional Center RN in follow up on these activities.

2. Information regarding supports the person requires will be shared with qualified providers that offer services appropriate to meet the needs of the person;
3. Consumers and parent/guardian will be linked with responsive providers;
4. Consumers and parent/guardian will be offered guidance concerning factors to consider in selecting a provider;
5. If requested, staff from the regional center and or habilitation center will accompany consumers and parent/guardian on visits to providers they select;
6. Intensive follow-up will be provided by appropriate regional center professionals for a minimum of six months and frequent contact with the consumer and parent/guardian will be maintained to assess the success and appropriateness of the new living arrangement. Staff from the habilitation center will be available to consult with the consumer and family/guardian as well as the new provider for behavioral or other issues; and
7. Consumer and parent/guardian will have the option to change the decision to move to the MRDD Home and Community Based Comprehensive Waiver Medicaid Program and may return to the habilitation center campus or an Intermediate Care Facility for the Mental Retarded (ICF/MR) facility if community placement is not successful, based on the census of the facility. The staff will do everything possible to return a person to the facility they choose, if community placement is not successful.

It is possible that a person who is placed in the community with a strong person centered plan and all the appropriate supports may still not thrive in the new setting. Along with the provider, parents and guardians, our Division staff will vigilantly watch for signs that the placement is not working. We will move quickly to remedy any unsatisfactory issues, adjust/change services, change staff, change providers, etc. However, if the consumer and parent/guardian requests, we will return the person to a habilitation center or an ICF/MR facility. The planning team will first look for a location on the campus from which the person moved. If that is not achievable, then the planning team will look for a location on a campus as near to the parents/guardians as possible. Based on the very careful procedures and steps involved in the transition effort, it is anticipated very few situations will occur where this is necessary. Actions and decisions at all steps will be documented.

When the consumer and parent/guardian choose not to explore community living options, their decision will be respected. The consumer and parent/guardian can always reconsider this decision.

Again, it is hoped that this document will provide valuable information to you and help you raise additional questions or issues also important to you. Questions and comments about this process can be sent to:

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Step 1: When Exploring Community Living Is a Recommended Option

The decision by an Interdisciplinary team to consider a community residential option for an individual typically will occur at a quarterly or annual planning meeting when:

1. The person and parents/guardian have themselves requested to move to a less restrictive and well supported community placement. Persons requesting movement to the community may be citing their right under Title II of the Americans with Disabilities Act, which is the basis of the Olmstead Decision; or
2. Interdisciplinary team members review the type of supports the person requires to live in a less restrictive environment and determine the services and supports required are available to do so through the MRDD Comprehensive Home and Community Based Medicaid Waiver program. The Interdisciplinary Team will inform the person and parents/guardians of potential options and the consumer and parents/guardians will have the right to choose to continue receiving services in the ICF/MR Medicaid Program (i.e. a habilitation center or ICF/MR facility) or to transition to the MRDD Comprehensive Home and Community Based Medicaid Waiver Program in a community living arrangement.

The habilitation social services staff or the Transition Service Coordinator (whose work focuses on facilitating transition to community placement) will notify the person and parents/guardians that a quarterly or annual person centered plan meeting is due.

To facilitate the parents/guardians participation and assure a productive meeting, the Transition Service Coordinator with appropriate habilitation center staff will:

- Arrange a meeting date and time that is convenient for the individual and parents/guardians and send letters of confirmation to the parents/guardians on agreed upon time;
- Notify the individual and parents/guardian of the right to invite anyone they choose to attend and participate in the meeting; and
- Include interdisciplinary team members in the meeting and notify appropriate local regional center staff to attend. The regional center case manager is considered to be a member of the interdisciplinary team and will assist the Transition Service Coordinator in any way to ensure that the new, community-based person-centered plan incorporates the objectives and information necessary for a successful transition to the community.

Step 2: When the Person, Parents/Guardians Agree to Explore Community Options:

1. The Transition Service Coordinator and habilitation center social services staff will work with regional center staff to identify providers for the person and parents/guardians to consider visiting (see Step 4). Appropriate habilitation center and regional center staff will be available to join the parents/guardians or they can visit on their own with other advocates of their choosing.

   In identifying providers that may be able to meet the person's needs, what is important to and for the person must be identified. Factors such as geographic location, friends, work, and specific needs will be considered. This information will be included in the person centered plan.

2. To minimize potential transfer trauma (physical or emotional), each person will be assessed by Habilitation Center medical staff. An individual's transition plan will identify and accommodate any concerns raised by the nurse or physician and will also include information about the individual's previous reactions to stressful situations. The team will proactively plan ways to monitor and provide previously successful interventions and support and refer that information to the Regional Center RN.

   Progress toward community placement and efforts to overcome any barriers to placement will be reviewed on a monthly basis.

3. Parents/guardians will be informed of quality assurance and follow-up monitoring activities. The follow-up activities will provide an opportunity to discuss interests of the person, methods that would be successful in resolving issues, and other items of detail that, while important, may not be outlined in the person centered plan. Documentation from the follow up activities will be shared as appropriate. The person centered plan must be modified as needed (see Step 4).

   The Regional Center Registered Nurse and the Habilitation Center medical staff will identify any medical issues that must be monitored, as well as the frequency of future follow up activities. Staff from the habilitation center will be available to consult for behavioral or other issues.

4. Before an individual is transitioned from a habilitation center to the community, their Medicaid eligibility must be verified to assure continued coverage once they leave the habilitation center. If there is a possibility the individual's Medicaid eligibility status would be jeopardized, the parent/guardian must be made aware of this fact, since it may impact their decision to transition the individual to the community.

Step 3: When Consumers, Parent/Guardian Decide Not to Explore:

1. If parents/guardians decide not to explore a recommended community residential placement, the planning team will explain their right to continue receiving Medicaid ICF/MR services through a habilitation center or ICF-MR facility. It is a requirement that the person has that right as long as the person's needs require that level of support.

   In the event that the building in which a person resides is to be vacated or a reconfiguration of persons served within a building requires a person to relocate, the planning team will first make every effort to re-locate the person looking for another location on the existing campus where the person is currently residing. If this is not achievable, the parent/guardian will be shown an alternative campus as near to the parent/guardians/guardians as possible.

2. The individual and parents/guardians always have the right to reconsider their decision. Multiple opportunities will be made available to provide information about community residential options. Information sources might include provider fairs, informative literature, and "Informed Choice" meetings that

provide a range of information to anyone interested in attending (attendance requires parent/guardian approval).

Step 4: Developing a New Community-Oriented Plan and Locating Community Options:

1. Individual Person Centered Plans for persons leaving a habilitation center must be designed and written in such a way as to clearly communicate to providers all of the needs and service supports being met at the habilitation center. The new, community oriented plan must be written to serve as a bridge into the community, outlining how these specific needs and supports can be met once the person has transitioned to a community living arrangement. The plan must be viewed as a document subject to change as the individual's responses and needs change.

2. Each individual will be offered a choice of provider. This may be done in conjunction with the development of a transition plan or may occur later. Assurances regarding ability to meet medical and/or behavioral needs must be given to the regional center, the habilitation center, and the family/guardian by a potential provider before they may be selected.

3. The Transition Service Coordinator will coordinate visits with the individual and family/guardian to locate and visit providers. The entire process of consumer choice of provider must be honored; however the choices for obvious reasons must include only those providing agencies that are qualified to meet the specialized needs of the individual. The Transition Service Coordinator will provide for the individual and family/guardian the names of other family members and/or advocates who have agreed to be a resource in providing information regarding community living. Families will be encouraged to contact these individuals.

Step 5: Quality Assurance:

The state, through the Division of MRDD, is responsible for ensuring that all persons with mental retardation and developmental disabilities who are supported by the Division, whether they reside in a habilitation center or community residential setting, receive services in the least restrictive environment that meets the person's individual health and safety requirements while assuring quality of life.

Persons in community residential placement benefit from quality assurance activities designed to pre-empt problems from occurring. When problems do occur, quality assurance activities exist to investigate, identify the cause and remedy it.

1. Intensive Quality Assurance Activities: When a person transitions to the community from a habilitation center, special oversight and quality assurance go into effect, as outlined below:

(a) Appropriate MRDD staff (e.g., case manager, nurse, QA staff) visit residents as frequently as necessary, for as long a time period as necessary, to ensure safety and correction of any problems with the provider's delivery of appropriate services;

(b) Following any move of a resident from a habilitation center to community residential placement, appropriate MRDD staff will visit the resident with increased frequency for six months. After six months, the interdisciplinary team will determine if routine quality assurance procedures are sufficient;

(c) The purpose of the visits is to assess the overall health, welfare and care regimen to ensure the person's condition has not regressed since leaving the habilitation center. Staff at the habilitation center who previously worked with the individual and who are familiar with the person's specialized care needs will be available to confer with provider staff and to make recommendations on treatment methods.

2. Routine and On-Going Quality Assurance Activities:

After six months of intense follow-up, if the transition team approves, the person will transition to the routine policy for on-going quality assurance as follows:

(a) Case managers visit residents face-to-face in community residential placement on a monthly basis and make observations about the resident's welfare, discuss any unmet needs with provider, alert parent/guardian to any adverse changes, and seek additional professional input as appropriate.

- Supervisors of case managers assess the comprehensiveness of visits made by case managers.

(b) The community provider RN employed by community residential providers is responsible for medication administration practices and other on-going medication support being in compliance with state standards and the Nurse Practice Act.

(c) Regional Center nurses are a critical resource to conduct further assessments/evaluations for case managers and providers when there are concerns about the health of a resident in community placement.

(d) Division of MRDD and provider staff are mandated reporters and in compliance with state statute must hot-line abuse and neglect to the Department of Health and Senior Services, and immediately enter a report into the Incident and Injury Tracking System (iITS). A report triggers immediate and appropriate follow-up by MRDD staff and, depending on the circumstances, the Department of Mental Health's Office of Quality Management (OQM), Licensure and Certification Unit.

(e) Parents/guardians are critically important in providing timely information to the provider and the MRDD case manager about any concerns about a person's well-being or health status.

(f) All community providers must be qualified. Most are either licensed or certified:

(1) The Department's OQM Licensure and Certification Unit makes on-site survey visits every year for a license and every two years for a certificate. The results of these surveys are discussed with QA staff in the Division and

Regional Center staff. The Division and Regional Center staff will work with the provider to make any changes or improvements in service delivery recommended by the Licensure and Certification Unit; and

(2) National accreditation organizations, such as CARF or the Council on Accreditation, are used by some community residential providers to assure consumers and the Division that they are providing quality services. If a provider agency is accredited by an organization recognized by the Department, that accreditation will be accepted by the Department and the Division in lieu of Department of Mental Health licensure and certification. However, all of the activities outlined in this section (a) through (3) still occur, as do those in Intensive Quality Assurance Activities above.

(g) Missouri Advocates for Individuals with Developmental Disabilities (MOAIDD) is a state-wide volunteer organization comprised of persons with disabilities who reside in the community or members of their families. These volunteers visit individuals at the convenience of the person and only with the individual's or their parent/guardian's permission. Their focus is on the individual and his/her rights, dignity, and quality of life. Volunteers are trained to observe and report objectively what they see in the daily life of the individual. They provide information to the individual, the service provider, and the appropriate MRDD Regional Center. The Regional Center takes appropriate follow-up action whenever there are negative reports. All reports made to the Regional Center and follow-up action are documented.

(h) The Division's Home and Community Based Medicaid Waiver which finances the overwhelming majority of consumers in community residential placement is subject to periodic inspection from the single state Medicaid agency (Division of Medical Services) and the federal agency, Centers for Medicare and Medicaid (CMS). CMS also requires assurances from the Division that the state uses a quality assurance system that includes multiple methods of oversight (such as those outlined in this entire section) to complement the federal periodic inspection process.

PLEASE NOTE THAT ATTACHED IS A FLOW CHART OF THE STEPS DESCRIBED IN THIS PROCESS. THIS FLOW CHART CANNOT BE SENT BY E-MAIL, SO IF YOU ARE RECEIVING THIS DOCUMENT BY E-MAIL, PLEASE CALL THE DIVISION AT (573) 751-8676 AND ASK FOR THE FLOW CHART. WE WILL BE PLEASED TO FAX OR MAIL IT TO YOU.

APPENDIX D

Division Directive Number 4.040

Effective Date: July 1, 2003

REVISION DATE: March 10, 2004

Anne S. Deaton, Ed.D., Director

Title: Referrals and discharges to and from state operated habilitation centers

Application: Applies to all Regional Centers and Habilitation Centers. An evaluation tool to analyze the effectiveness of this policy shall also be implemented and reviewed periodically.

Purpose: This policy outlines procedures and documentation requirements for Habilitation Center and Regional Center staff concerning admissions and discharges to and from Habilitation Centers, as well as documentation and meeting requirements regarding individuals while they are at the Habilitation Center.

1. Throughout this policy, the definition for "interdisciplinary team" or "team" shall be: "Those individuals (family members, professionals, paraprofessionals, and non-professionals) who possess the knowledge, skills and expertise necessary to accurately identify the comprehensive array of the individual's needs and design a program which is responsive to those needs (ICF-MR interpretive guidelines)."
2. An individual's interdisciplinary team shall be represented by those individuals that can identify needs and design a program to meet those needs. This includes all appropriate facility staff as well as participation by other agencies serving, or those which will serve the individual when discharged, such as the regional center.
3. An "expanded" interdisciplinary team is the addition of members to the interdisciplinary team as defined in number 1 above. These members should include, but not be limited to:
   - Family advocate (if requested by the person or guardian)
   - Member of the habilitation center
   - Member of the community (i.e., representative from the Regional Advisory group, personal advocate, other state agency)
   - Two community providers (rotated on a regular basis)
   - A SB 40 Board representative (rotated on a regular basis) if available and appropriate.
4. The duties of the Expanded interdisciplinary team shall include, but not be limited to:

- Identification of barriers to placement in the community (by review of information sent to and from the regional center);
- Development of an action plan that includes timelines for overcoming the barriers'
- Comment or make recommendations if, after 90 days, the placement in the community is not achieved;
- Conform to all HIPAA requirements related to sharing of Personal Health Information (PHI).

5. For those individuals residing in habilitation centers that would like to move to the community and their guardian and interdisciplinary team are in agreement, the habilitation center and regional center shall give them top priority, as they may fall under the Olmstead Decision.

   DOCUMENTATION NEED: The Regional Center shall track the time between the date the request to move is made to the Regional Center and the actual date the move is finalized.
6. For those individuals residing in habilitation centers whose guardians want to maintain the placement at the habilitation center, but the interdisciplinary team feels community placement would meet their needs, the team shall document the guardians' concerns leading to their decision to not consider the community.
   DOCUMENTATION NEED: Documentation as to the need for continued ICF/MR services must also occur, as this is necessary for both Habilitation Center placement, and also placement under the Home and Community Based Waiver guidelines. The regional center and habilitation center staff shall document efforts to alleviate concerns expressed by guardians, while exploring/developing viable community living options.
7. For all persons currently residing in state operated habilitation centers, the interdisciplinary team shall assess appropriate residential options at their regularly scheduled review and planning meetings, which are held at least quarterly. At the time of assessment, all residential options will be reviewed with the person and/or their guardian, as well any advocate the person or guardian may invite. The person and/or their guardian shall be notified prior to the time of all meetings, and of their right to invite an advocate of their choice. Notification of this right shall be included in information provided to a person and/or their guardian at the time of their admission to the habilitation center, and prior to any assessment or planning meetings. Assessment or planning meetings shall be scheduled to accommodate the person and/or their guardian, including evenings and weekends if needed.
8. Additionally, the interdisciplinary team shall ascertain in which of the following four categories an individual would be best described:
   - Individual wants to move, and the interdisciplinary team and guardian are in agreement. This scenario may be covered by the Olmstead Decision.
   - Individual could move, however some accommodations must be made, or there are barriers present. For example, community readiness must occur before successful transition can occur, or a certain skill must be further developed. It must be determined by the team if the specific situation is considered to be covered by the Olmstead Decision, and should be documented accordingly.

- Parents/guardians want to maintain placement at a habilitation center and are not agreeing to community options at this time.

NOTE: Individuals/guardians in the above three groups shall be notified annually of the opportunity to meet with an Informed Choice volunteer and/or Regional Center service coordinator to discuss community options and procedures for making requests to move to the community. However, individuals and/or their guardians may request to meet with an Informed Choice volunteer and/or Regional Center service coordinator at any time. It is the responsibility of the Regional Center Service Coordinator working in concert with the Habilitation Center to ensure individuals and/or their guardians understand this may occur at their choice.

- High Risk (health and safety), and best current option is state operated facility (additional training and supports needed, and community options need to be developed). Some examples include forensic, sexual predator, extremely aggressive, very medically compromised, etc.

NOTE: Categorization is for the Division's use only, and not something that is included into the consumer's personal plan.

9. New admissions to state operated habilitation centers shall be considered time limited, in that discharge criteria and planning must begin upon admission, unless the person is offered community services and chooses the habilitation center, community provider capacity is not immediately available, or the person has been admitted by the Court or has forensic status. Admission to the state operated habilitation center will be based on most critical need first.
10. The census of all state operated habilitation centers shall not exceed 1,467 (FY 02 funded levels of all state operated habilitation centers). Referrals may be made by the regional center at any time, but the habilitation center cannot accept an admission without the approval of the District Deputy if an individual habilitation center is at or over census.
11. A referral form and risk assessment shall be completed by the Regional Center to determine the appropriateness of the referral. Services in another state operated or private ICF/MR could be offered as an option if the person refuses community services and the habilitation center is over census, and the individual meets ICF-MR criteria. However, the regional center will be primarily responsible for finding services in the community for a person in the habilitation center if the habilitation center is at or over census.
12. Processing requests for community residential supports initiated by the habilitation center shall be the responsibility of the regional center and must be expedited.
    DOCUMENTATION NEED: The Regional Center shall document and maintain records of attempts to make referrals and barriers to those referrals, as well as referrals made. The documentation shall be reported on a monthly basis to the interdisciplinary team, who shall document the results in the personal plan review, that efforts are underway to meet an individual's determined needs in a community based setting. However, documentation

that the person continues to require the ICF/MR level of care must be maintained.

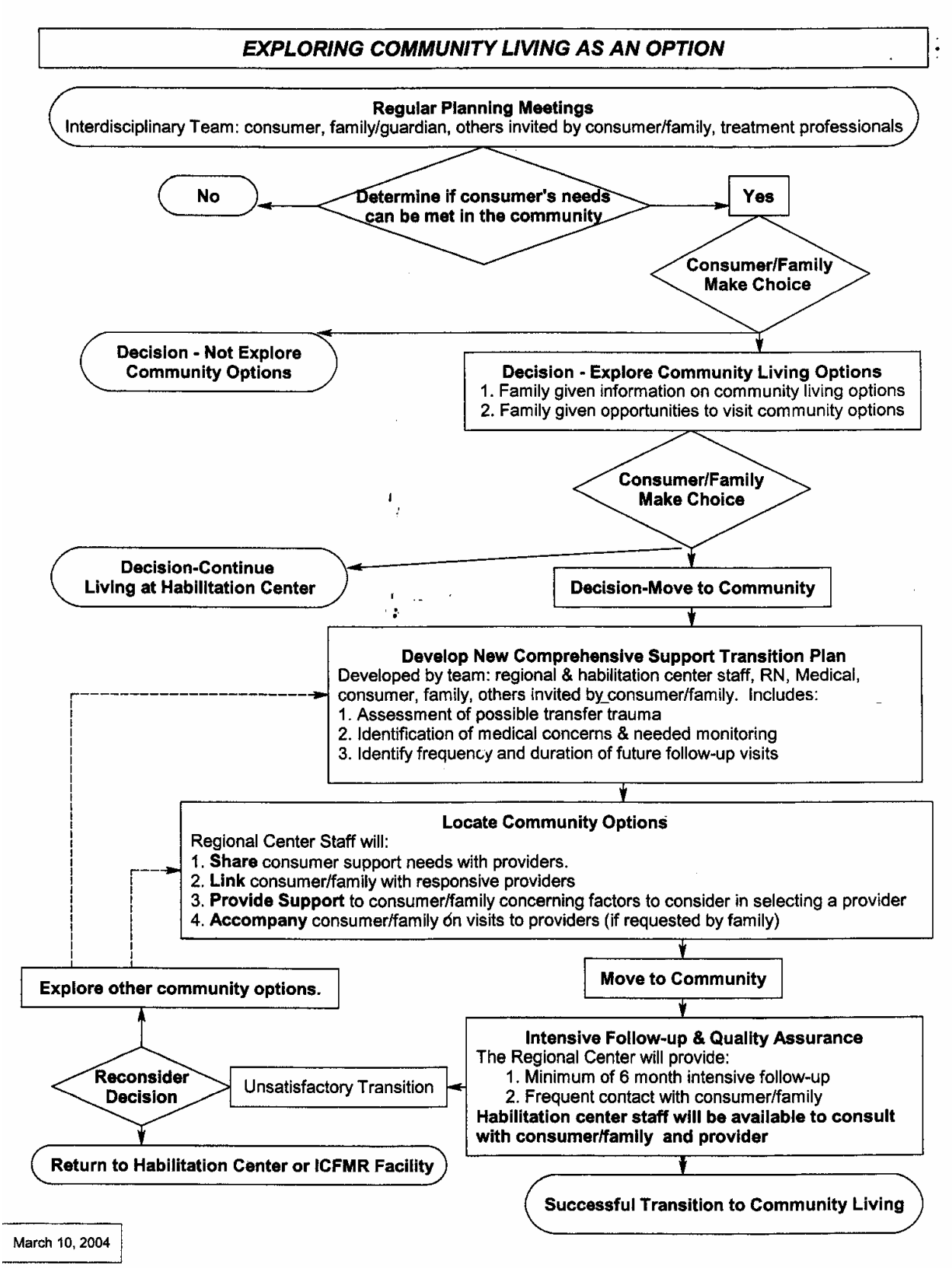
13. All new admissions to state operated habilitation centers shall be reviewed by the interdisciplinary team at thirty (30) days to determine if the person has a continued need for habilitation center services. Persons admitted by Court Order, the forensic process, and persons clinically determined dangerous to themselves or others, or those for whom the person or their guardian choose the state operated habilitation center as their residence are exempt from this process. At 60 days, please refer to #19 below.
14. Each regional center shall designate a person(s) who is responsible for initiating and tracking all referrals to state operated habilitation centers. This individual shall work closely with the service coordinator or other member of the interdisciplinary team, to coordinate referrals. Additionally, the regional center Director or Assistant Director and the Superintendent or Assistant Superintendent of Habilitation for the habilitation center shall be involved in referrals to state operated habilitation centers. All referrals in and out of the state operated habilitation centers shall be coordinated in this fashion. **No other system will be utilized.**
15. Regional Center service coordinators and other appropriate staff shall participate in planning as a member of the interdisciplinary team for those individuals who are either admitted into the habilitation center under this policy, or who have been identified as being in one of the top two categories indicated in number eight (8) above.
16. In any case in which the interdisciplinary team believes the individual is able to reside in the community, but the person and/or guardian insists on the state operated habilitation center, the staff shall continue to work with the person and/or their guardian to inform them of all community options available.

    DOCUMENTATION NEED: The progress that has been made toward developing community options, or to alleviate guardian concerns shall be documented during personal plan review meetings by the interdisciplinary team. Again, it is important to continue documentation that the person continues to require an ICF/MR level of care for both the ICF placement at the habilitation center, and for the Medicaid Waiver.
17. Requests for **temporary, intensive treatment** at state operated habilitation centers shall be for **30 days only and may only be renewed one time with the recommendation of the interdisciplinary team and approval by the Regional Center Director and the Superintendent of the Habilitation Center.** If the stay is to be longer than 60 days, see # 19 below.
18. The regional center and habilitation center staff shall work with the person and/or their guardian to make preparations for the person to transition into the community prior to or no later than the 30 day expiration time limit. The transition process is guided by best practices outlined by the division, and shall include input from direct support professionals who have supported the person during their stay at the habilitation center. Appropriate health professionals such as nurses, physicians, and Regional Center nurses, will review a person's health and safety needs prior to a move to the community and assure supports are in place to support them and minimize any transfer trauma.

    DOCUMENTATION NEED: This review will be documented in the person's file and attested to by the signature of the health professional involved.

Follow along tracking jointly by the Habilitation Center and the Regional Center shall occur for six months.

19. After 60 days, the person's support needs will be reviewed by an expanded interdisciplinary team that involves the participation of the Regional Center Director and the habilitation center Superintendent or their designees. As indicated in number 3 above, the expanded interdisciplinary team should include representatives of, but not be limited to, the following:
    - Family advocate (if requested by the person or guardian)
    - Member of the support team (habilitation center representative)
    - Member of the community (i.e., representative from Regional Council, advocate, other state agency)
    - Two community providers (rotated on a regular basis)
    - A SB 40 Board representative (rotated on a regular basis) if available and appropriate.
20. **DOCUMENTATION NEED:** The expanded interdisciplinary team shall:
    - Identify barriers to placement in the community (by review of information sent to and from the regional center);
    - Develop an action plan that includes timelines for overcoming the barriers;
    - Indicate in action plan date for follow-up meeting;
    - Record types of barriers that have been raised;
    - Record the number of times the expanded team must meet;
    - Comment or make recommendations if, after 90 days, the placement is the community is not achieved, and forward the documentation to the deputy director for habilitation services, the deputy director for community services, and director of policy;
    - Document successes of removing barriers with successful community placement to share with the deputy director for habilitation services, the deputy director for community services, and director of policy; and,
    - The "expanded" interdisciplinary team shall conform to all HIPAA requirements related to sharing Personal Health Information (PHI).
21. When multiple service options are available to meet a person's needs, health and safety are the primary considerations. Choice, cost, utilization review, quality and capacity shall also be taken into consideration.
22. This policy in no way prevents individuals who are eligible for ICF/MR services and whose needs cannot be safely met in the community from remaining in the habilitation center. In addition, persons who are eligible for ICF/MR services and who choose institutional services over community services may remain in the habilitation center or transferred to another ICF/MR facility (state operated or private) that has the capacity to meet the person's needs elsewhere in Missouri, by mutual consent of the District Deputies.


EXPLORING COMMUNITY LIVING AS AN OPTION
Regular Planning Meetings
Interdisciplinary Team: consumer, family/guardian, others invited by consumer/family, treatment professionals
Determine if consumer's needs can be met in the community
No
Yes
Consumer/Family Make Choice
Decision - Not Explore Community Options
Decision - Explore Community Living Options
1. Family given information on community living options
2. Family given opportunities to visit community options
Consumer/Family Make Choice
Decision-Continue Living at Habilitation Center
Decision-Move to Community
Develop New Comprehensive Support Transition Plan
Developed by team: regional & habilitation center staff, RN, Medical, consumer, family, others invited by consumer/family. Includes:
1. Assessment of possible transfer trauma
2. Identification of medical concerns & needed monitoring
3. Identify frequency and duration of future follow-up visits
Locate Community Options
Regional Center Staff will:
1. Share consumer support needs with providers.
2. Link consumer/family with responsive providers
3. Provide Support to consumer/family concerning factors to consider in selecting a provider
4. Accompany consumer/family on visits to providers (if requested by family)
Explore other community options.
Move to Community
Intensive Follow-up & Quality Assurance
The Regional Center will provide:
1. Minimum of 6 month intensive follow-up
2. Frequent contact with consumer/family
Habilitation center staff will be available to consult with consumer/family and provider
Reconsider Decision
Unsatisfactory Transition
Return to Habilitation Center or ICFMR Facility
Successful Transition to Community Living
March 10, 2004